CHAPTER V

BILLING PROCEDURES

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CHAPTER V
BILLING PROCEDURES

SUBMISSION OF CLAIMS

Dialysis centers will use the HCFA-1500 (12-90) for the submission of claims for renal dialysis services rendered to Medicaid recipients.

IMPORTANT:

- When billing on the HCFA-1500 **(12-90)** claim form, Virginia Medicaid will accept an **original** form printed in red ink with the appropriate certifications on the reverse side (bar coding is optional). **Additionally, only the HCFA-1500 (12-90) form will be accepted; no other HCFA-1500 form will be accepted.**

- Laser-printed copies of the HCFA-1500 (12-90) will be accepted as long as the back of the claim is printed.

  The requirement to submit claims on an original HCFA-1500 (12-90) form is necessary because the individual signing the invoice is attesting to the statements on the reverse side, and, therefore, these statements become part of the original billing invoice.

ELECTRONIC SUBMISSION OF CLAIMS

Providers may submit claims by direct dial-up at no cost per claim, using toll-free telephone lines. Electronic Data Interchange (EDI) is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered into the claims processing system directly. Most personal, mini, or mainframe computers can be used for electronic billing.

TIMELY FILING

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims which **are not** submitted within 12 months from the date of the service. If billing electronically and timely filing must be waived, submit the claim on paper with the appropriate attachments. Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished timely, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility** - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for a recipient whose eligibility has been delayed. When the provider did not have knowledge of the Medicaid eligibility of the person prior to rendering the care or service, he or she has 12 months from the date he or she is notified of the Medicaid eligibility in which to file the claim. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

  The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the letter from the local department of social services indicating the delayed claim information must be attached to the claim. On the HCFA-1500 (12-90) form, enter "ATTACHMENT" in Locator 10d and indicate "Unusual Service" by entering Procedure Modifier "22" in Locator 24D.

- **Rejected or Denied Claims** - Rejected or denied claims submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

  - Complete the HCFA-1500 (12-90) invoice as explained under the “Instructions for the Use of the HCFA-1500 (12-90) Billing Form” elsewhere in this chapter.

  - **Attach** written documentation to verify the explanation. This documentation may be denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period.

  - Indicate Unusual Service by entering "22" in Locator 24D of the HCFA-1500 (12-90) claim form.

  - Submit the claim in the usual manner using the preprinted envelopes supplied by Medicaid or by mailing the claim to:

Department of Medical Assistance Services
Practitioner
P. O. Box 27444
Richmond, Virginia 23261-7444

Submit the original copy of the claim form to Medicaid. Retain a copy for record keeping. All invoices must be mailed; proper postage is the responsibility of the provider and will help prevent mishandling. Envelopes with insufficient postage will be returned to the provider. Messenger or hand deliveries will not be accepted.

- **Exceptions** - The state Medicaid agency is required to adjudicate all claims within 12 months of receipt except in the following circumstances:

  - The claim is a retroactive adjustment paid to a provider who is reimbursed under a retrospective payment system.

  - The claim is related to a Medicare claim which has been filed in a timely manner, and the Medicaid claim is filed within six months of the disposition of the Medicare claim.

  - This provision applies when Medicaid has suspended payment to the provider during an investigation and the investigation exonerates the provider.

  - The payment is in accordance with a court order to carry out hearing decisions or agency corrective actions taken to resolve a dispute or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those affected by it.

  The procedures for the submission of these claims are the same as previously outlined. The required documentation should be written confirmation that the reason for the delay meets one of the specified criteria.

- **Accident Cases** - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired.

BILLING INVOICES

The requirements for the submission of billing information and the use of the appropriate billing invoice depend upon the type of service being rendered by the provider and/or the billing transaction being completed. Listed below are the three billing invoices to be used for billing dialysis services:

- Health Insurance Claim Form HFCA-1500 (12-90)
- Title XVIII (Medicare) Deductible and Coinsurance Invoice (DMAS-30)
- Title XVIII (Medicare) Deductible and Coinsurance Adjustment Invoice (DMAS-31)

REQUESTS FOR BILLING MATERIALS

The HCFA-1500 (12-90) is a universally accepted claim form that is required when billing DMAS for covered services. The form is available from forms printers and the U. S. Government Printing Office. **The HCFA-1500 (12-90) will not be provided by DMAS.** The envelopes will continue to be supplied.

The Client Materials Management Unit of the Department of Medical Assistance Services is responsible for the distribution of all forms supplied by DMAS.

The Department of Medical Assistance Services Request for Forms/Brochures (DMAS-161) or Request for Billing Supplies (DMAS-160), as appropriate, must be used by providers to order forms or brochures. (See the "Exhibits" section at the end of this chapter for samples of these forms.) A six-month supply of forms should be ordered at least three (3) weeks prior to the anticipated need.

The Request for Forms/Brochures or Request for Billing Supplies must be submitted to:

DMAS Order Desk
North American Marketing
3703 Carolina Avenue
Richmond, VA 23222

Direct any requests for information or questions concerning the ordering of forms to the address above or call: (804) 329-4400.

Any requests for information or questions concerning the ordering of forms should be directed to the address shown above, or call (804) 329-4400.

BASIS OF PAYMENT

Request for payment must be made under the Medicaid eligibility number of the person receiving the services and whose Medicaid eligibility number appears on the billing invoice.

Federal regulation 42 CFR 447.15 requires providers to accept Medicaid payment as payment in full for the service rendered. The provider may not bill DMAS or the recipient for the difference (if any) between the allowed amount and the actual provider's charge.

The provider must bill any other possibly liable third party prior to billing DMAS. DMAS

will pay the difference between the Program's allowable fee and any payment made by a third party if that payment is less than the allowable fee.

When Medicare (Title XVIII) makes a payment for a provider's covered services, the provider may claim payment of any deductible and coinsurance amounts due from DMAS. However, he or she may not claim payment of the difference (if any) between the Medicare allowed fee and his or her actual fee for services. Also, Medicaid payments for Medicare Part B coinsurance are limited to the difference between Medicaid's maximum fee for a given procedure and Medicare's payment for that procedure. The combined payments by Medicare and Medicaid will not exceed Medicaid's allowed charge for that procedure. (Effective July 1, 1998)

(See “EXHIBITS” at the end of this chapter for a sample form of the DMAS-160 and DMAS-161.)

INSTRUCTIONS FOR THE USE OF THE HCFA-1500 (12-90) BILLING FORM

To bill for services, the Health Insurance Claim Form, HCFA-1500 (12-90), invoice form must be used. The following instructions have numbered items corresponding to fields on the HCFA-1500. **The required fields to be completed are printed in boldface. Where more specific information is required in these fields, the necessary information is referenced in the locator requiring the information and provider-specific instructions are found on page 19.** (See "EXHIBITS" at the end of this chapter for a sample of this form.)

Instructions for the Completion of the Health Insurance Claim Form, HCFA-1500 (12-90), Billing Invoice

The purpose of the HCFA-1500 is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid recipients. (A sample of a completed HCFA-1500 claim form follows the instructions for its use.)

Locator		Instructions
1	**REQUIRED**	**Enter an "X" in the MEDICAID box.**
1a	**REQUIRED**	**Insured's I.D. Number - Enter the 12-digit Virginia Medicaid Identification number for the recipient receiving the service.**
2	**REQUIRED**	**Patient's Name - Enter the name of the recipient receiving the service as it appears on the identification card.**
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Patient Status
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Other Insured's Date of Birth and Sex

Locator		Instructions
9c	NOT REQUIRED	Employer's Name or School Name
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	**REQUIRED**	**Is Patient's Condition Related To: - Enter an "X" in the appropriate box. (The "Place" is NOT REQUIRED.)** **a. Employment? b. Auto Accident? c. Other Accident? (This includes schools, stores, assaults, etc.)**
10d	**CONDITIONAL**	**Enter "ATTACHMENT" if documents are attached to the claim form or if procedure modifier "22" (unusual services) is used.**
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Employer's Name or School Name
11c	NOT REQUIRED	Insurance Plan or Program Name
11d	NOT REQUIRED	Is There Another Health Benefit Plan?
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy
15	NOT REQUIRED	If Patient Has Had Same or Similar Illness
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	**CONDITIONAL**	**Name of Referring Physician or Other Source**
17a	**CONDITIONAL**	**I.D. Number of Referring Physician - Enter the 7-digit Virginia Medicaid number of the referring physician. See the following pages for special instructions for your services.**
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	NOT REQUIRED	Reserved for Local Use
20	NOT REQUIRED	Outside Lab?

Locator		Instructions
21	**REQUIRED**	**Diagnosis or Nature of Illness or Injury - Enter the appropriate ICD-9 CM diagnosis which describes the nature of the illness or injury for which the service was rendered.**
22	**CONDITIONAL**	**Medicaid Resubmission - Required for adjustment and void. See the instructions for Adjustment and Void Invoices.**
23	NOT REQUIRED	Prior Authorization Number
24A	**REQUIRED**	**Dates of Service - Enter the from and thru dates in a 2-digit format for the month, day, and year (e.g., 04/01/99). DATES MUST BE WITHIN THE SAME CALENDAR MONTH.**
24B	**REQUIRED**	**Place of Service - Enter the 2-digit HCFA code which describes where the services were rendered. See the Place of Treatment Codes list following the instructions for the appropriate code entry.**
24C	**REQUIRED**	**Type of Service - Enter the one-digit HCFA code for the type of service rendered. See the code list following the instructions for the appropriate code entry.**
24D	**REQUIRED**	**Procedures, Services or Supplies** **CPT/HCPCS - Enter the 5-character CPT/HCPCS Code which describes the procedure rendered or the service provided. See the attached code list for special instructions if appropriate for your service.** **Modifier - Enter the appropriate HCPCS/CPT modifiers if applicable. See the list of modifiers following the instructions for the appropriate entry.**
24E	**REQUIRED**	**Diagnosis Code - Enter the entry identifier of the ICD-9CM diagnosis code listed in Locator 21 as the primary diagnosis. NOTE: Only one code is processable.**
24F	**REQUIRED**	**Charges - Enter your total usual and customary charges for the procedure/services. See the special instructions following these instructions if applicable for your service.**

24G REQUIRED **Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period. See the pages following the instructions for special instructions if applicable to your service.**

24H CONDITIONAL **EPSDT or Family Plan - Enter the appropriate indicator. Required only for EPSDT or family planning services.**

1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services

2 - Family Planning Service

24I CONDITIONAL **EMG (Emergency) - Place a "1" in this block if the services are emergency-related. Leave blank if not an emergency.**

24J REQUIRED **COB (Primary Carrier Information) - Enter the appropriate code. See special instructions if required for your service.**

2 - No Other Carrier

3 - Billed and Paid

5 - Billed, No Coverage. All claims submitted with a Coordination of Benefits (COB) code of 5 must have an attachment documenting one of the following:

- **The Explanation of Benefits (EOB) from the primary carrier; or**
- **A statement from the primary carrier that there is no coverage for this service; or**
- **An explanation from the provider that the other insurance does not provide coverage for the service being billed (e.g., this is a claim for surgery and the other coverage is dental); or**
- **A statement from the provider indicating that the primary insurance has been canceled.**

Claims with no attachment will be denied for reason 495, "Other Insurance Information Missing." Providers who submit claims

electronically must indicate a value of "6" in field 38 *(Document Indicator)* of the EA0 record and a value of "B" in field 39 *(Type of Documentation)* to indicate that there is an attachment to this claim. In addition, the HA0 record, *Service Line Narrative*, must contain a narrative description of the information that is on file in the provider's office to support COB code 5 for the claim being submitted.

24K	**REQUIRED**	**Reserved for Local Use - Enter the dollar amount received from the primary carrier if Block 24J is coded "3." See special instructions if required for your service.**
25	NOT REQUIRED	Federal Tax I.D. Number
26	**OPTIONAL**	**Patient's Account Number - Seventeen alpha-nu-numeric characters are acceptable.**
27	NOT REQUIRED	Accept Assignment
28	NOT REQUIRED	Total Charge
29	NOT REQUIRED	Amount Paid
30	NOT REQUIRED	Balance Due
31	**REQUIRED**	**Signature of Physician or Supplier Including Degrees or Credentials - The provider or agent must sign and date the invoice in this block.**
32	NOT REQUIRED	Name and Address of Facility Where Services Were Rendered
33	**REQUIRED**	**Physician's, Supplier's Billing Name, Address ZIP Code & Phone # - Enter the provider's billing name, address, ZIP Code, and phone number as they appear in your Virginia Medicaid provider record. Enter your 7-digit Virginia Medicaid provider number in the PIN # field. Ensure that your provider number is distinct and separate from your phone number or ZIP Code.**

Instructions for the Completion of the Health Insurance Claim Form, HCFA-1500 (12-90), as an Adjustment Invoice

The Adjustment Invoice is used to change information on a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, HCFA-1500 (12-90), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code - Enter the 3-digit code identifying the reason for the submission of the adjustment invoice.

523 Primary Carrier has made additional payment
524 Primary Carrier has denied payment
525 Accommodation charge correction
526 Patient payment amount changed
527 Correcting service periods
528 Correcting procedure/service code
529 Correcting diagnosis code
530 Correcting charges
531 Correcting units/visits/studies/procedures
532 IC reconsideration of allowance, documented
533 Correcting admitting, referring, prescribing, provider identification number

Original Reference Number - Enter the 9-digit claim reference number of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each HCFA-1500 submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim.)

Instructions for the Completion of the Health Insurance Claim Form HCFA-1500 (12-90), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, HCFA-1500 (12-90), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code - Enter the 3-digit code identifying the reason for the submission of the void invoice.

542 Original claim has multiple incorrect items
544 Wrong provider identification number
545 Wrong recipient eligibility number
546 Primary carrier has paid DMAS maximum allowance
547 Duplicate payment was made
548 Primary carrier has paid full charge
551 Recipient not my patient
552 Void is for miscellaneous reasons
560 Other insurance is available

Original Reference Number - Enter the 9-digit claim reference number of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each HCFA-1500 submitted as a Void Invoice. (Each line under Locator 24 is one claim.)

PLACE OF SERVICE CODES

HCFA - 1500 CODE

00-10	Unassigned
11	Office location
12	Patient's home
13-20	Unassigned
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room
24	Ambulatory surgical center
25	Birthing center
26	Military treatment center
27-30	Unassigned
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
35-40	Unassigned
41	Ambulance - land
42	Ambulance - air or water
43-50	Unassigned
51	Inpatient psychiatric facility
52	Psychiatric facility - partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
57-60	Unassigned
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
63-64	Unassigned
65	**End stage renal disease treatment facility**
66-70	Unassigned
71	State or local public health clinic
72	Rural health clinic
73-80	Unassigned
81	Independent laboratory
82-98	Unassigned
99	Other unlisted facility

TYPE OF SERVICE CODES

CODE	DESCRIPTION
1	**Medical care**
2	Surgery
3	Consultation
4	Diagnostic x-ray
5	Diagnostic laboratory
6	Radiation therapy
7	Anesthesia
8	Assistance at surgery
9	Other medical care
0	Blood or packed red cells
A	Used DME
F	Ambulatory surgical center
H	Hospice
L	Renal supplies in the home
M	Alternate payment for maintenance dialysis
N	Kidney donor
V	Pneumococcal vaccine
Y	Second opinion on elective surgery
Z	Third opinion on elective surgery

PROCEDURE MODIFIERS

HCPCS/CPT

TC	**Technical Component**
22	**Unusual services**
26	**Professional component**
50	Bilateral procedure
51	Multiple procedures
52	Reduced services
75	Concurrent care
80	Assistant surgeon
81	Minimum assistant surgeon
82	Assistant surgeon

PROCEDURE MODIFIERS FOR EPSDT

MODIFIER CODE

H		**No abnormalities found, no treatment required, and no referral required**
K		**Abnormality found, treatment has been initiated by myself, and no other referral required**
T	*	**Abnormality found, treatment has been initiated by myself, and referral to another practitioner has been made**
U	*	**Abnormality found, no treatment has been initiated by myself, and referral to another practitioner has been made**
W		**Abnormality found, no treatment has been made at this time, referral to myself for treatment within the next 120 days**
Y		**Abnormality found, treatment/referral has been refused by the recipient or the responsible adult in the case**
Z		**Abnormality found, no treatment has been initiated, no referral has been made. The recipient is already under care.**

*** When a physician makes abnormality referrals to other practitioners, the names of the practitioners and the appointment dates must be provided on an attachment and the word "ATTACHMENT" entered in Locator 10d.**

SPECIAL BILLING INSTRUCTIONS

CLIENT MEDICAL MANAGEMENT PROGRAM

The primary care physician bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. Covered outpatient services excluded from this requirement include: renal dialysis clinic services, routine vision care services, BabyCare services, personal care services (respite care or adult day health care), ventilator-dependent services, EPSDT, and prosthetic services.

All services should be coordinated with the primary health care provider whose name appears on the recipient's eligibility card. Other DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

A physician, treating a restricted recipient as a physician covering for the primary care physician or on referral from the primary care physician must place the primary care physician's Medicaid provider number (as indicated on the recipient identification card) in Locator 17a and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "1" in Locator 24I and attach an explanation of the nature of the emergency.

LOCATOR	SPECIAL INSTRUCTIONS
10d	Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70, or for remarks as appropriate.
17a	When a restricted recipient is treated on referral from the primary physician, enter the primary care physician's Medicaid provider number (as indicated on the card) and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice. Write "ATTACHMENT" in Locator 10d.
24I	When a restricted recipient is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a "1" in this Locator and explains the nature of the emergency in an attachment. Write "ATTACHMENT" in Locator 10d.

SPECIAL BILLING INSTRUCTIONS

MEDALLION

Primary Care Providers (PCP) bill for services on the Health Insurance Claim Form, HCFA-1500 (12-90). The invoice is completed and submitted according to the instructions provided in the Medicaid *Physician Manual*.

To receive payment for their services, referral providers authorized by a client's PCP to provide treatment to that client must place the Medicaid Provider Identification Number of the PCP in Locator 17a of the HCFA-1500. Subsequent referrals resulting from the PCP's initial referral will also require the PCP Medicaid provider number in this block.

SPECIAL BILLING INSTRUCTIONS

FREESTANDING RENAL DIALYSIS CLINIC MANUAL

Locator 24D **Procedures, Services or Supplies**

CPT/HCPCS - Enter the procedure codes appropriate for the services rendered from the list given below. Dialysis codes M0916 and M0931 include the supplies used during treatment and the following routine laboratory tests: complete blood count (RBC, WBC, Hgb, Hct, WBC differential, platelet count), hepatitis profile (Anti-HAV, Anti HAV-IgM, HBsAg, H Be Ag, Anti-HBs, Anti-H Bc, Anti H Bc-IgM, and Anti-H Be), and blood chemistry tests (albumin, albumin/globulin ratio, alkaline phosphatase, bilirubin [total and direct], calcium, carbon dioxide content, chlorides, cholesterol, creatinine, globulin, glucose, lactic dehydrogenase, phosphorous, potassium, sodium, SGOT, SGPT, total protein, urea nitrogen, and uric acid). Use the appropriate *Physicians' Current Procedural Terminology* (CPT) or HCPCS codes for non-routine laboratory tests that are actually performed by the dialysis center.

Procedure codes for billing services are:

M0931	**Peritoneal dialysis**
M0916	**Hemodialysis**
93000	**Electrocardiogram, EKG**
P9010	**Blood**
36430	**Blood administration**

To bill for medications administered by injection during the course of treatment, use the appropriate HCPCS code for the substance(s) given.

INSTRUCTIONS FOR BILLING MEDICARE COINSURANCE AND DEDUCTIBLE

Virginia Medicaid purchases Medicare Part B coverage for all Medicaid recipients eligible for Medicare benefits and makes payment to providers for Medicare coinsurance and deductible.

The Medicare Program Part B Carriers serving Virginia and the Virginia Medicaid Program have developed a system whereby these carriers will send to Virginia Medicaid the Medicare Explanation of Benefits (EOB) for identified Virginia recipients. This information will be used by the Program to pay Medicare coinsurance and deductible amounts as determined by the carrier. Do not bill Virginia Medicaid directly for services rendered to Medicaid recipients who are also covered by Medicare Program Part B carriers serving Virginia. However, the DMAS-31 adjustment form may be used when needed.

If the Medicare Part B carrier is one of these, bill Medicare directly on the appropriate invoice.

Upon receipt of the Medicare EOB, Virginia Medicaid will process payment automatically to participating providers when the recipient's Medicare number and the provider's Medicare vendor/provider number are in the Medicaid files. Those providers billing Medicare under more than one Medicare vendor/provider number must identify these numbers and names to the Medicaid Program to update its files. Medicare vendor/provider number additions or deletions must also be sent to the Program.

This automatic payment procedure includes Medicaid recipients with Railroad Retirement Medicare benefits.

If problems are encountered, the DMAS-30 invoice form should be completed, and a copy of the EOB attached and forwarded to:

Practitioner
Department of Medical Assistance Services
P. O. Box 27444
Richmond, Virginia 23261-7444

NOTE: Medicaid eligibility is reaffirmed each month for most recipients. Therefore, bills must be for services provided during each calendar month, e.g., 01-01-99 - 01-31-99.

INSTRUCTIONS FOR THE COMPLETION OF THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (TITLE XVIII) MEDICARE DEDUCTIBLE AND COINSURANCE INVOICE, DMAS-30 (REVISED 1/91)

Purpose To provide a method of billing Medicaid for Medicare deductible and coinsurance. (See "EXHIBITS" at the end of this chapter for a sample of this form.)

Explanation

Block 1 **Transmission Code** - This is a number assigned and preprinted by the Department of Medical Assistance Services.

Block 2 **Provider Identification Number** - Enter the seven-digit provider identification number assigned by Medicaid and the provider name and address.

Block 3 **Recipient's Name** - Enter the last name and the first name of the patient as they appear on the recipient's eligibility card.

Block 4 **Recipient Identification Number** - Enter the 12-digit number taken from the recipient's eligibility card.

Block 5 **Patient Account Number** - If a numbering system is used by the provider for patient identification, enter the patient's number in this block. This number will appear on the Remittance Voucher preceding the name. If no such system is used, leave this block blank.

Block 6 **Recipient HIB Number (Medicare)** - Enter the recipient's Medicare number.

Block 7 **Primary Carrier Information (Other Than Medicare)** - Check the appropriate block. (Medicare is not the primary carrier in this situation.)

- **Code 2 - No Other Coverage** - If the Carrier Code on the recipient's Medicaid eligibility card is blank, indicating no other coverage, or contains the code 001 (Medicare), check Block 2.

- **Code 3 - Billed and Paid** - When a recipient has other coverage that makes payment which may only satisfy in part the Medicare deductible and coinsurance, check Block 3 and enter the payment received in Block 19. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid

- **Code 5 - Billed and No Coverage** - If the recipient has other

sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 8 **Type Coverage (Medicare)** - Mark type of coverage "B."

Block 9 **Diagnosis** - Enter the primary ICD-9-CM diagnosis code, omitting the decimal. Only one code can be processed.

Block 9A **Place of Treatment** - Enter the appropriate HCFA code (see instructions for HCFA-1500:

00	Unassigned
11	Office
12	Home
10, 13-20	Unassigned
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room—hospital
24	Ambulatory surgical center
25	Birthing center
26	Military treatment center
27-29	Unassigned
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
30, 35-39	Unassigned
41	Ambulance--land
42	Ambulance, air or water
40, 43-49	Unassigned
51	Inpatient psychiatric facility
52	Psychiatric facility partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
50, 57-59	Unassigned
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
60, 63-64	Unassigned
65	End stage renal disease treatment facility
66-69	Unassigned
71	State or local public health clinic
72	Rural health clinic
70, 73-79	Unassigned
81	Independent laboratory
80, 82-89	Unassigned
99	Other unlisted facility

90-98 Unassigned

Block 10 **Accident Indicator** - Check the appropriate box which indicates the reason the treatment was rendered:

Accident - Possible third-party recovery
Emergency - Not an accident
Other - If none of the above

Block 11 **Type of Service** - Enter the appropriate HCFA code:

0	Whole Blood	H	Hospice
1	Medical Care	J	Diabetic shoes
2	Surgery	K	Hearing items and services
3	Consultation	L	ESRD supplies
4	Diagnostic Radiology	M	Monthly capitation payment for dialysis
5	Diagnostic Laboratory	N	Kidney donor
6	Therapeutic Radiology	P	Lump sum purchase of DME, prosthetics, orthotics
7	Anesthesia		
8	Assistant at surgery	Q	Vision items or services
9	Other medical items or services	R	Rental of DME
A	Used DME	S	Surgical dressings or other medical supplies
B	High risk screening mammography	T	Psychological therapy
C	Low risk screening mammography	U	Occupational therapy
D	Ambulance	V	Pneumococcal/flu vaccine
E	Enteral/parenteral nutrients/supplies	W	Physical therapy
F	Ambulatory surgical center	Y	Second opinion on elective surgery
G	Immunosuppressive drugs	Z	Third opinion on elective surgery

Block 11A **Procedure Code** - Enter the 5-digit CPT/HCPCS code which was billed to Medicare. Each procedure must be billed on a separate line. If there was no procedure code billed to Medicare, leave this block blank. Use the appropriate HCFA procedure code modifier if applicable.

Block 11B **Visits/Units/Studies** - Enter the units of service performed during the "Statement Covers Period" as billed to Medicare.

Block 12 **Date of Admission** - Leave blank.

Block 13 **Statement Covers Period** - Using six-digit dates, enter the

beginning and ending dates of this service (from) and the last date of this service (thru), e.g., 01-01-92 to 01-31-92.

Block 14 **Charges to Medicare** - Enter the total charges submitted to Medicare.

Block 15 **Allowed by Medicare** - Enter the amount of the charges allowed by Medicare.

Block 16 **Paid by Medicare** - Enter the amount paid by Medicare (taken from the EOB).

Block 17 **Deductible** - Enter the amount of the deductible (taken from the Medicare EOB).

Block 18 **Coinsurance** - Enter the amount of the coinsurance (taken from the Medicare EOB).

Block 19 **Paid by Carrier Other Than Medicare** - Enter the payment received from the primary carrier (other than Medicare). If Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments.)

Block 20 **Patient Pay Amount, LTC Only** - Leave blank.

Signature Signature of the provider or the agent and the date signed are required.

Mechanics and Disposition Information as explained above may either be typed or legibly handwritten. If an explanation regarding this claim is necessary, the "Remarks" section may be used. Separate and forward the original copy, along with a copy of the EOB attached, in the envelope supplied by the Program. Retain the provider's copy in the office files. Mail the completed claims to:

Practitioner
Department of Medical Assistance Services
P. O. Box 27444
Richmond, Virginia 23261-7444

INSTRUCTIONS FOR THE COMPLETION OF THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (TITLE XVIII) MEDICARE DEDUCTIBLE AND COINSURANCE ADJUSTMENT INVOICE, DMAS-31 (REVISED 1/91)

Purpose To provide a means of making corrections or changes to claims that have been approved for payment. This form cannot be used for the follow-up of denied, rejected, or pended claims. (See "EXHIBITS" at the end of this chapter for a sample of this form.)

Explanation To void the original payment, the information on the adjustment invoice must be identical to the original invoice. To correct the original payment, the adjustment invoice must appear exactly as the original should have.

Block 1 **Adjustment/Void** - Check the appropriate block.

Block 2 **Provider Identification Number** - Enter the seven-digit provider identification number assigned by Medicaid which will be used for processing.

Block 2A **Reference Number** - Enter the reference number taken from the Title XVIII Deductible and Coinsurance Remittance Voucher for the line of payment needing adjustment. The reference number (nine digits) follows the recipient's eligibility number on the remittance voucher. The adjustment cannot be made without this number since it identifies the original invoice.

Block 2B **Reason** - Leave blank.

Block 2C **Input Code** - Leave blank.

Blocks 3-20 Refer to the instructions for the completion of the DMAS-30 for the completion of these blocks.

Remarks This section of the invoice should be used to give a brief explanation of the change needed.

Signature The signature of the provider or the authorized agent and the date signed are required.

Mechanics and Disposition The form may either be typed or legibly handwritten. Separate and forward the intermediary copy in the preaddressed envelope supplied by the Program. Retain the provider's copy in the office files.

The correct address is:

Practitioner
Department of Medical Assistance Services
P. O. Box 27444
Richmond, Virginia 23261-7444

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, microfilmed, a cross-reference number assigned (e.g. 123-45678-9), and entered into the system, it is placed in one of the following categories:

- **Rejects** - Unprocessable for some reason and returned to the provider. These claims should be resubmitted on a new invoice with corrected data.
- **Remittance Voucher Shows**
  - **Approval** - Payment is approved.
  - **Pended** - For manual adjudication (provider must not resubmit)
  - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
- **No Response** - **If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form.**

The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing. If the voucher or reject does not provide the necessary answer, then contact the Provider Inquiry Unit to resolve any questions on billings or payments. The address for this unit is:

Provider Inquiry Unit
Division of Client Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

REMITTANCE VOUCHER (Payment Voucher)

DMAS sends a remittance voucher with each payment. This voucher is a listing of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five years.

The check is the last item in the envelope. The remittance voucher includes an address sheet which has been added for security purposes. The address sheet contains a space for special messages from DMAS.

Participating providers are encouraged to monitor the remittance vouchers for special messages that will expedite notification on matters of concern. This mechanism may be used to alert providers on matters that may relate to:

- Pending implementation of policies and procedures
- Sharing clarification on a concern expressed by a provider

If assistance is needed, call the Medicaid HELPLINE numbers:

786-6273	Richmond area
1-800-552-8627	All other areas

The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays.

Recipient verification may be obtained by telephoning:

1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

EXHIBITS

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

REQUEST FOR BILLING SUPPLIES

Name_____ Date _____

Provider Number_____ Contact Person _____

Telephone # (_____) _____
(Area Code)

Check As Appropriate

_____ Please forward preprinted invoices as indicated below.
_____ Please forward invoices suitable for computer use as indicated below.
_____ Other (See Order Below)

Quantity:	Dental:
_____	DMAS-701 Invoice
_____	DMAS-702 Invoice Adjustment
_____	DMAS-704 Preauthorization Req
_____	DMAS-703 Envelope
	Home Health Agency:
_____	DMAS-662 Envelope
	Hospital:
_____	DMAS-660 Envelope
	Laboratory:
_____	DMAS-123 Invoice
_____	DMAS-230 Invoice Adjustment
_____	DMAS-665 Envelope
	Nursing Home:
_____	DMAS-215 Invoice
_____	DMAS-262 Invoice Adjustment
_____	DMAS-661 Envelope
	Personal Care: NOT PREPRINTED
_____	DMAS-93 Invoice
_____	DMAS-94 Invoice Adjustment
_____	DMAS-659 Envelope

Quantity:	Pharmacy:
_____	DMAS-173 Drug Claim Ledger
_____	DMAS-228 Drug Claim Adjustment
_____	DMAS-664 Envelope
	Practitioner:
_____	DMAS-663 Envelope
	Special Service: NOT PREPRINTED
_____	DMAS-199 Invoice
_____	DMAS-233 Invoice Adjustment
_____	DMAS-666 Envelope
	Title XVIII: NOT PREPRINTED
_____	DMAS-30 (Medicare) Deductible and Coinsurance Invoice
_____	DMAS-31 Invoice Adjustment
	Transportation: NOT PREPRINTED
_____	DMAS-7 Invoice
_____	DMAS-8 Invoice Adjustment
_____	DMAS-666 Envelope
_____	DMAS-9 Verification Form

Please return this form to: DMAS Order Desk
North American Marketing
3703 Carolina Avenue
Richmond, Virginia 23222

DMAS-160 R 3/94

Department of Medical Assistance Services Request for Forms/Brochures

Name_____ Date _____

Provider Number_____ Contact Person _____Telephone # (____) _____

Quantity	Form Number	Form Name
____	DMAS-16	Maternity Risk Screen
____	DMAS-17	Infant Risk Screen
____	DMAS-20	Consent Form for Release of Information, Rev 1/90
____	DMAS-50	Maternal Care Coordinator Record (25/pad)
____	DMAS-51	Infant Care Coordinator Record (25/pad)
____	DMAS-52	Care Coordination Service Plan (25/pad)
____	DMAS-53	Pregnancy Outcome Report (25/pad)
____	DMAS-54	Infant Outcome Report (25/pad)
____	DMAS-55	Care Coordination Letter of Agreement (25/pad)
____	DMAS-70	Practitioner Referral Form
____	DMAS-77	ICF/MR Utilization Review Assessment
____	DMAS-77A	Programs/Objective Continuation Sheet
____	DMAS-80	Patient Intensity Rating System Review (50/pad)
____	DMAS-89	Personal Care Recipient Admissions Envelope
____	DMAS-90	Personal Care Aide Record (25/pad)
____	DMAS-95	UAI Assessment Process
____	DMAS-95A	UAI Assessment Process (part A only)
____	DMAS-95B	UAI Assessment Process (part B only)
____	DMAS-95MI/MR	Supplemental Assessment Process Form
____	DMAS-96	Nursing Home Pre-Admission Screening Plan
____	DMAS-97	Plan of Care for Personal Care Services (25/pad)
____	DMAS-97A	Provider Agency Plan of Care (25/pad)
____	DMAS-99	Community-Based Care Recipient Assessment Report (25/pad)
____	DMAS-100	Request for Supervision in Personal Plan of Care (25/pad)
____	DMAS-101	MH/MR Service Needs Summary (25/pad)
____	DMAS-113A	Medicaid HIV Services Pre-Screening Assessment
____	DMAS-113B	Medicaid HIV Waiver Services Prescreening Plan of Care
____	DMAS-114	AIDS Waiver Authorization Form
____	DMAS-115	Nutritional Information Form
____	DMAS-119	Social History Form
____	DMAS-121	Certificate of Patient Status (50/pad)
____	DMAS-121-A	Cert. of Patient Rehabilitative Services (50/pad)
____	DMAS-122	Patient Information R 12/98 (50/pad)
____	DMAS-125	Rehabilitation Treatment Authorization (25/pad)
____	DMAS-175	Pharmacist Intervention Report (25/pad)
____	DMAS-177	Patient Counseling Log (25/pad)
____	DMAS-201	Notification of Medicaid Transportation Denial
____	DMAS-212	Title XIX Enrollment (50/pad)
____	DMAS-300	Respite Care Needs Assessment and Plan of Care
____	DMAS-301	Adult Day Health Interdisciplinary Plan of Care
____	DMAS-302	Adult Day Health Care Daily Log
____	DMAS-351	Pre-Authorization Request (50/pad)
____	DMAS-352	Certification of Medical Necessity
____	DMAS-353	EPSDT Documentation Form
____	DMAS-354	IV Therapy Implementation Form
____	DMAS-412	Medicaid Request for Psych. Extension Treatment (25/pad)
____	DMAS-420	Request for Hospice Benefits
____	DMAS-421	Hospice Benefits Revocation/Change Statement
____	DMAS-500	HIPP Application
____	DMAS-501	HIPP Medical History Questionnaire
____	DMAS-502	HIPP Employer Verification
____	DMAS-503	HIPP Policy Holder Information
____	DMAS-1000	Third Party Liability Information Report
____	DMAS-3004	Sterilization Consent Form
____	DMAS-3005	Acknowledgement of Receipt of Hysterectomy Information
____	DMAS-3006	Abortion Certification R 3/99
____	DMAS-4000	Prosthetic Device Preauthorization Form

Quantity	Form Number	Brochure Name
____	SLH-1	Hospital Brochure
____	DMAS-1	EPSDT Pamphlet
____	DMAS-2	Virginia Medicaid Handbook
____	DMAS-14E	Medallion Brochure (English)
____	DMAS-14S	Medallion Brochure (Spanish)
____	DMAS-60	BabyCare (English)
____	DMAS-61	BabyCare (Spanish)
____	DMAS-62	BabyCare (Vietnamese)
____	DMAS-63	BabyCare (Laotian)
____	DMAS-64	BabyCare (Cambodian)
____	DMAS-67	Planning Ahead: A Guide for Virginians with Disabilities
____	DMAS-350	CMSIP Handbook

Quantity	Envelope Number	Envelope Name
____	DMAS-660	Hospital Inpatient/Outpatient
____	DMAS 663	HCFA-1500 Mailing
____	DMAS-89	Personal Care Recipient Admissions
____	SLH-24	SLH Mailing

Please return this form to: DMAS Order Desk
North American Marketing
3703 Carolina Avenue
Richmond, Virginia 23222

DMAS 161 R 4/99

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, MIddle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes,*** return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . ___ 3. ____ . ___

2. ____ . ___ 4. ____ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

091

1 TRANSMISSION CODE | 2 PROVIDER I.D. NO.(7)

0

3 RECIPIENT'S LAST NAME | FIRST NAME | 4 RECIPIENT I.D. NUMBER (12) | 5 PATIENT ACCOUNT NUMBER | 6 RECIPIENT'S HIB NUMBER (MEDICARE)

7 PRIMARY CARRIER INFORMATION OTHER THAN (MEDICARE)
☐ 2 NO OTHER COVERAGE
☐ 3 BILLED AND PAID
☐ 5 BILLED NO COVERAGE

8 TYPE COVERAGE (MEDICARE) ☐ A ☐ B | 9 DIAGNOSIS | 9A PLACE OF TREAT. (2) | 10 ACCIDENT/EMERG INDICATOR ☐ ACC ☐ EMER ☐ OTHER | 11 TYPE SERV (1-2) | 11A PROCEDURE CODE (5) | 11B VISITS/UNITS STUDIES (3) | 12 DATE OF ADMISSION MO (2) DAY (2) YEAR (2) | 13 STATEMENT COVERS PERIOD FROM MO (2) DAY (2) YEAR (2) THRU MO (2) DAY (2) YEAR (2)

14 CHARGES TO MEDICARE | 15 ALLOWED BY MEDICARE | 16 PAID BY MEDICARE | 17 DEDUCTIBLE | 18 COINSURANCE | 19 PAY BY CARRIER OTHER THAN MEDICARE | 20 PATIENT PAY AMOUNT LTC ONLY

1

3 RECIPIENT'S LAST NAME | FIRST NAME | 4 RECIPIENT I.D. NUMBER (12) | 5 PATIENT ACCOUNT NUMBER | 6 RECIPIENT'S HIB NUMBER (MEDICARE)

7 PRIMARY CARRIER INFORMATION OTHER THAN (MEDICARE)
☐ 2 NO OTHER COVERAGE
☐ 3 BILLED AND PAID
☐ 5 BILLED NO COVERAGE

8 TYPE COVERAGE (MEDICARE) ☐ A ☐ B | 9 DIAGNOSIS | 9A PLACE OF TREAT. (2) | 10 ACCIDENT/EMERG INDICATOR ☐ ACC ☐ EMER ☐ OTHER | 11 TYPE SERV (1-2) | 11A PROCEDURE CODE (5) | 11B VISITS/UNITS STUDIES (3) | 12 DATE OF ADMISSION MO (2) DAY (2) YEAR (2) | 13 STATEMENT COVERS PERIOD FROM MO (2) DAY (2) YEAR (2) THRU MO (2) DAY (2) YEAR (2)

14 CHARGES TO MEDICARE | 15 ALLOWED BY MEDICARE | 16 PAID BY MEDICARE | 17 DEDUCTIBLE | 18 COINSURANCE | 19 PAY BY CARRIER OTHER THAN MEDICARE | 20 PATIENT PAY AMOUNT LTC ONLY

2

3 RECIPIENT'S LAST NAME | FIRST NAME | 4 RECIPIENT I.D. NUMBER (12) | 5 PATIENT ACCOUNT NUMBER | 6 RECIPIENT'S HIB NUMBER (MEDICARE)

7 PRIMARY CARRIER INFORMATION OTHER THAN (MEDICARE)
☐ 2 NO OTHER COVERAGE
☐ 3 BILLED AND PAID
☐ 5 BILLED NO COVERAGE

8 TYPE COVERAGE (MEDICARE) ☐ A ☐ B | 9 DIAGNOSIS | 9A **PLACE OF TREAT.** (2) | 10 ACCIDENT/EMERG INDICATOR ☐ ACC ☐ EMER ☐ OTHER | 11 TYPE SERV (1-2) | 11A PROCEDURE CODE (5) | 11B VISITS/UNITS STUDIES (3) | 12 DATE OF ADMISSION MO (2) DAY (2) YEAR (2) | 13 STATEMENT COVERS PERIOD FROM MO (2) DAY (2) YEAR (2) THRU MO (2) DAY (2) YEAR (2)

14 CHARGES TO MEDICARE | 15 ALLOWED BY MEDICARE | 16 PAID BY MEDICARE | 17 DEDUCTIBLE | 18 COINSURANCE | 19 PAY BY CARRIER OTHER THAN MEDICARE | 20 PATIENT PAY AMOUNT LTC ONLY

3

3 RECIPIENT'S LAST NAME | FIRST NAME | 4 RECIPIENT I.D. NUMBER (12) | 5 PATIENT ACCOUNT NUMBER | 6 RECIPIENT'S HIB NUMBER (MEDICARE)

7 PRIMARY CARRIER INFORMATION OTHER THAN (MEDICARE)
☐ 2 NO OTHER COVERAGE
☐ 3 BILLED AND PAID
☐ 5 BILLED NO COVERAGE

8 TYPE COVERAGE (MEDICARE) ☐ A ☐ B | 9 DIAGNOSIS | 9A PLACE OF TREAT. (2) | 10 ACCIDENT/EMERG INDICATOR ☐ ACC ☐ EMER ☐ OTHER | 11 TYPE SERV (1-2) | 11A PROCEDURE CODE (5) | 11B VISITS/UNITS STUDIES (3) | 12 DATE OF ADMISSION MO (2) DAY (2) YEAR (2) | 13 STATEMENT COVERS PERIOD FROM MO (2) DAY (2) YEAR (2) THRU MO (2) DAY (2) YEAR (2)

14 CHARGES TO MEDICARE | 15 ALLOWED BY MEDICARE | 16 PAID BY MEDICARE | 17 DEDUCTIBLE | 18 COINSURANCE | 19 PAY BY CARRIER OTHER THAN MEDICARE | 20 PATIENT PAY AMOUNT LTC ONLY

REMARKS: IDENTIFY LINE ITEM TO WHICH REMARKS REFER

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE DATE

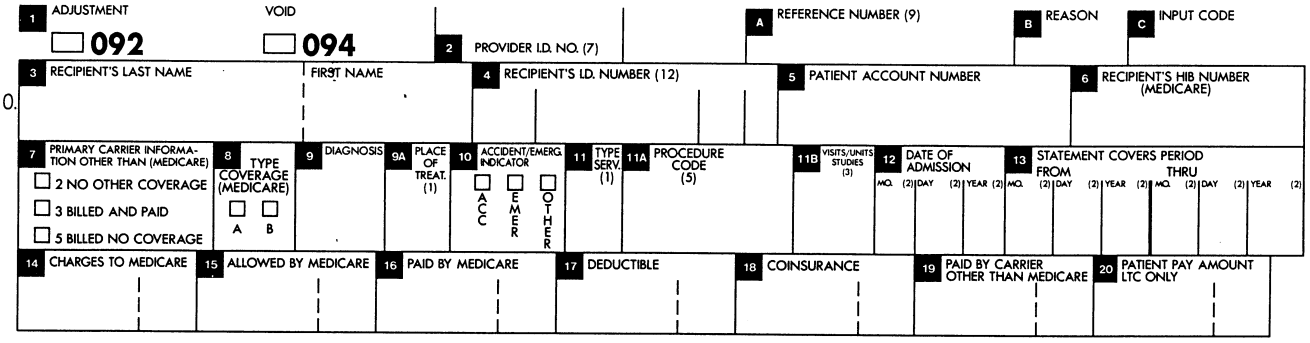
ORIGINAL COPY

DMAS - 30 R 4/96

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES



0.

_____ DATE OF REMITTANCE VOUCHER CLAIM WAS APPROVED

THIS FORM IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER OF THE PAID CLAIM AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.

REMARKS:

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE DATE

ORIGINAL COPY

DMAS 31 R 1/91